North East **LHIN**

Annual Report
2008 – 2009

Ontario
Local Health Integration Network

North East LHIN Region

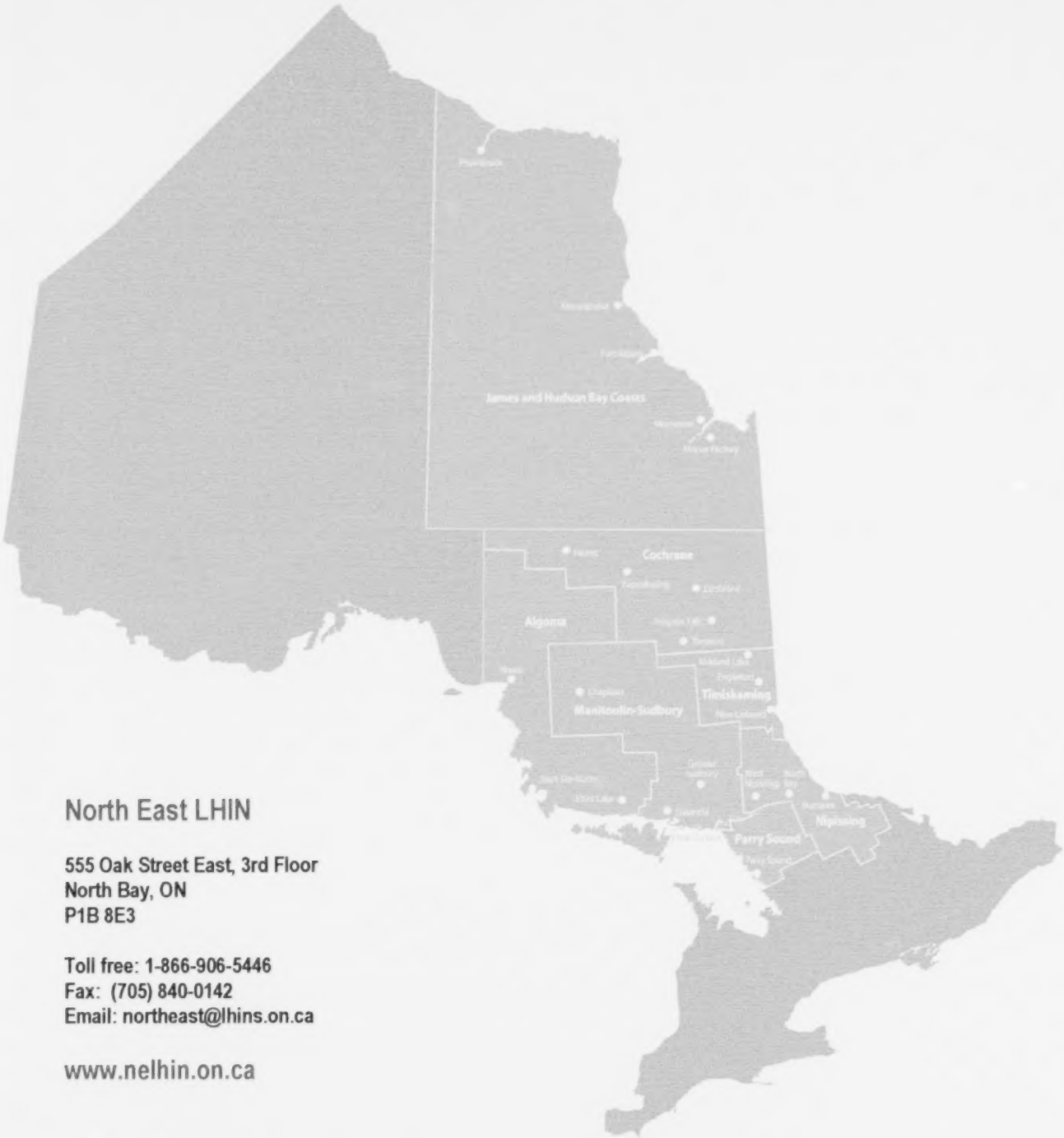

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Table of Contents

NE LHIN Vision and Mission Statement

"Health & Wellness for all ... through an innovative, sustainable and accountable system."

Values

Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs and opportunities and act appropriately.
Equity	Opportunity for health and wellness for all.
Serve	Include North East Ontario geographic, cultural, demographic and linguistic health and wellness needs in all activities.

Message from the Board Chair and CEO

During 2008/2009, in the midst of an environment changed by the global economic slow-down, the NE LHIN focused on collaboration in order to maintain its strategic momentum.

Organizations, individuals and government programs – including health care – paused to refocus their energies in view of a deteriorating global financial situation.

This milieu created new challenges and opportunities for the NE LHIN and its partners. Our LHIN took the mindset that we must continue to work towards creating an environment where health care can be optimally delivered by streamlining the current assets and by doing things differently, with the same amount or possibly fewer resources. Part of the solution rests within the application of our ***Integration Strategy*** – moving from independent organizations to interdependent ones.

The NE LHIN's 2008/09 operational plan focused on two priorities: (1) care delivery, making decisions in the best interest of the people served; and (2) sustainability, making decisions to ensure the long-term sustainability of our health care system.

We are proud of our achievements in 2008/09 in meeting the objectives within these priorities, some of which included:

- **Integrated Health Service Plan (IHSP)**
  Moving forward on our seven priorities.

- **Aging at Home**
  Allocating $4.3 million to 26 projects across the region to help seniors stay in their own homes longer.

- **Alternate Level of Care (ALC)**
  Working with community partners to find solutions to our ALC challenge; patients occupying a hospital bed while waiting for placement within supportive housing or a long-term care home, or availability of community services to help them stay at home longer.

- **Integration Strategy**
  Working with health service providers to identify integration opportunities.

- **e-Health**
  Working to implement Ontario's new e-Health Strategy which aims to have an electronic record in place across the province by 2015.

Mathilde Gravelle Bazinet
Chair

Rémy Beaudoin
CEO

- **Accountability Agreements**
  Completing negotiations with 25 NE LHIN hospitals for the Hospital Service Accountability Agreements (H-SAA) and 135 Multi-Sectoral Service Accountability Agreements (M-SAA).

- **Aboriginal/First Nation/Métis Health**
  Supporting the implementation of Weeneebayko Area Health Authority (WAHA).

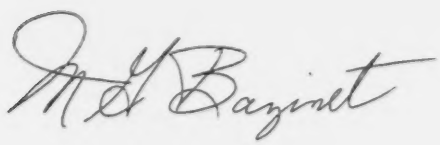
- **Francophone Health**
  Supporting the work of the French Language Services Working Group and ensuring accountability of health service providers to the Francophone population within their communities.

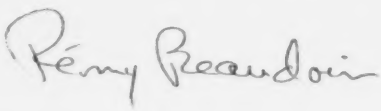
- **Health Professionals Advisory Committee**
  Working with committee members who represent the broad spectrum of the health care system and focusing on the system challenges related to patient flow and ALC bottlenecks.

We compliment the Board of Directors and staff of our organization who worked with great agility to respond to environmental challenges in 2008/09, while maintaining a strategic focus.

As the second-largest LHIN geographically in Ontario, the NE LHIN continues to work to ensure that we provide the more than 550,000 people and 200 health service providers in North East Ontario with a health system that is sustainable, patient-focused, and holds fewer service gaps.

We continue to be optimistic that health care systems can be improved as our collaborative team in the North East joins forces, and intellect, to make these positive changes a reality.





Mathilde Gravelle Bazinet
Chair, Board of Directors

Rémy Beaudoin
Chief Executive Officer

I. Welcome to our LHIN

Introduction

The changed economic environment of 2008/09 underscored that the NE LHIN would continue to be successful by working with its partners and stakeholders to overcome collective challenges. This year's annual report describes many efforts to surmount challenges within our NE LHIN region, as well as a healthy number of accomplishments.

Some of the challenges facing the NE LHIN and its partners in 2008/09, which could only be overcome through collaboration and a focus on better patient care including:

- The upward trend of alternate level of care (ALC) patients in hospital beds and the need to have a NE LHIN strategy that goes beyond existing health care programs and focuses specifically on supportive housing.
- The impending demographic tsunami of our region's aging population and its implications on health care programs. (It is projected that the NE LHIN will have a 24% increase in its seniors' population aged 65+ between 2006 and 2016 -- from 16.5% to 20.4%).
- Optimizing technology to effectively meet the health care needs of our dispersed population over a vast, remote and largely rural geography.
- Working with our hospital partners to help them achieve balanced budgets.
- Working with the culturally diverse population of our region in order to meet the unique health care needs of our Aboriginal/First Nation/Métis and Francophone people.

The solution to some of these challenges rests within the application of the NE LHIN ***Integration Strategy*** announced in September 2008. Despite the changes, challenges and fluctuations, one task remains clear: health organizations of our region must work together.

Pivotal to NE LHIN collaborative functioning is our expressed intention: "***You will be heard.***" The challenge of this objective across our vast region is being met through opportunities with new technologies. Demonstrating innovation, the NE LHIN used technology to ensure its *2008 Governance/Stakeholder Forum* provided two-way communication between 285 individuals at 24 regional sites. In addition, our use of on-line forums on our website, posting of pod casts and videography, proved to be successful in liaising with the many people and organizations we serve.

In summary, the NE LHIN Board of Directors and staff have worked hard since our organization's inception to manage the North East health care portfolio through a lens that focuses on doing things differently – analyzing the health care components in order to arrive at better/more focused formulas and establishing structures that ensure we are making decisions with all of our partners around the table.

Population and Health Profile

The *Demographic, Socioeconomic, and Population Health Profile* produced by the NE LHIN in November 2008 provided helpful insights into the people served within the NE LHIN geography and environment.

Not only is our region geographically complex, the human face of it merits special attention due to its unique characteristics. These differences are acknowledged and respected by the NE LHIN.

The NE LHIN extends to a vast geographic area of approximately 400,000 square kilometres, with a population of more than 550,000. Our region is home to 1.4 persons per square kilometre. When compared to the provincial population density of 13.4 persons per sq. km (Southern Ontario has a population density of approximately 100 persons per sq. km), it is not surprising that there are significant challenges to providing health care in the NE LHIN. In addition, the rate of population growth in the NE LHIN is nearly stagnant at less than 1%, compared to the provincial growth rate of nearly 8% since the 2001 Census.

Our region has a cultural make-up that is quite different from that of Ontario overall. For example, almost one-quarter of our population (24%) is Francophone (compared to less than 5% of the provincial population) and 10% of our population is Aboriginal, First Nation or Métis compared to less than 2% provincially. We also have a higher proportion of seniors in our population, 17% vs. 14% provincially. And, almost a third of our population lives in rural areas (30% compared to 15% provincially).

Within our region, there is also diversity in the populations of our seven geographic planning areas. The map below shows the geographic area served by these planning areas and the list below provides the names along with the approximate share of the population contained in the area:

- Algoma (21%)
- Cochrane (14%)
- James and Hudson Bay Coasts (1%)
- Manitoulin-Sudbury (35%)
- Nipissing (15%)
- Parry Sound (7%)
- Timiskaming (6%)

The map above shows the vast North East LHIN region which is served by seven geographic planning areas.

In addition to the difference in population size and geographic area served, there is also

variation on the basis of many demographic characteristics:

- The Francophone population in each of our planning areas varies from 3% in the Parry Sound area to 51% in the Cochrane area;
- The proportion of Aboriginal, First Nation or Métis population varies from 6% to 11%, while the majority of the James and Hudson Bay Coasts population is Aboriginal, First Nation or Métis;
- The proportion of the population that is age 65 and over varies from 14% in the Cochrane area to 21% in the Parry Sound area.

To ensure that services are the right fit within each planning area and community setting, these factors and many other critical systemic and demographic factors have been taken into account within the North East. Some of the other demographic differences as well as differences in health behaviours and health status are summarized below.

Overall, relative to the province, the North East has a higher:

- percentage of the population with Aboriginal, First Nation or Métis identity
- percentage of Francophones
- proportion of older people
- percentage of population living in rural areas
- percentage of daily smokers
- percentage of people exposed to second-hand smoke at home
- percentage of adults who are current drinkers reporting heavy drinking
- percentage of adults who are obese
- prevalence of self-report participation and activity limitations, arthritis, high blood pressure, diabetes and asthma
- mortality rate for all causes combined, and for many specific disease categories such as circulatory system diseases, cancer and injuries.

... and a lower:

- rate of population growth
- percentage with postsecondary education
- percentage of immigrants and visible minorities
- percentage with a regular medical doctor or contact with a medical doctor in last year
- prevalence of perceived health being very good or excellent..

Statistics such as these are vital for the funding, coordinating and integrating work of the NE LHIN. We are aware of areas which will exert pressure on our regional systems, including the following:

- It is projected that the NE LHIN will have a 24% increase in its seniors population (age 65+) between 2006 and 2016 (Ministry of Finance, 2007), from 16.5% to 20.4%.

- There are over 25,000 older persons (age 65+) living alone in the NE LHIN, 19% of males and 40% of females in that age group.

- Chronic conditions such as diabetes will be an increasing burden. The NE LHIN's geographic area is home to over 20% of the Ontario aboriginal population. Our region's overall rate of diabetes is 7.5% for ages 12+, and it is estimated that the rate of diabetes in the national aboriginal population is at least three times higher than for the non-aboriginal population.

II. NE LHIN Board of Directors

The nine-member NE LHIN Board of Directors had two vacant positions at the end of the 2008 fiscal year.

All Local Health Integration Networks are governed by an appointed Board of Directors. Each Board member is appointed by an Order-in-Council.

The NE LHIN Board of Directors holds open monthly board meetings across the NE LHIN. Three standing committees report directly to the Board, including: Governance Committee, Audit Committee and the Health Professionals Advisory Committee (HPAC).

Members of the NE LHIN Board 2008/09

Mathilde Gravelle Bazinet
Chair
NE LHIN Planning Area: Nipissing
(June 8, 2005 to June 9, 2009)

Peter Vaudry
NE LHIN Planning Area: Algoma
(May 17, 2006 to May 31, 2011)

Marc Dumont
NE LHIN Planning Area: Timiskaming
(May 17, 2006 to June 16, 2010)

Randy Kapashesit
NE LHIN Planning Area: James & Hudson Bay Coasts
(September 20, 2006 to September 19, 2009)

Johanne Labonté
NE LHIN Planning Area: Cochrane
(February 5, 2007 to February 4, 2010)

Brenda Roseborough
NE LHIN Planning Area: Manitoulin-Sudbury
(May 2008 to May 2011)

Leah Welk
NE LHIN Planning Area: Parry Sound
(September 24, 2008 to September 2011)

Dr. Donald Stemp
NE LHIN Planning Area: Nipissing
(May 17, 2006 to May 16, 2009)

Vacant
NE LHIN Planning Area: Manitoulin-Sudbury

III. Ministry-LHIN Accountability Agreement (MLAA)

The Ministry-LHIN Accountability Agreement (MLAA) clearly defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the NE LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance indicators within a pre-defined period of time.

The table on the following page outlines indicators measured during 2008/09.

North East LHIN MLAA Performance Indicators 2008-2009

Performance Indicator	LHIN 2008/09 Starting Point	LHIN 2008/09 Performance Target	Most Recent Quarter 2008/09	Annual * Results**	LHIN Met Target – Within Corridor YES/NO
90th Percentile Wait Times for Cancer Surgery [2]	57	55	51	55	YES
90th Percentile Wait Times for Cardiac By-Pass Procedures [2]	48	32	35	38	NO
90th Percentile Wait Times for Cataract Surgery [2]	134	130	111	125	YES
90th Percentile Wait Times for Hip Replacement [1]	405	320	374	371	NO
90th Percentile Wait Times for Knee Replacement [1]	380	290	359	423	NO
90th Percentile Wait Times for Diagnostic MRI Scan [1]	94	70	75	73	YES
90th Percentile Wait Times for Diagnostic CT Scan [1]	37	34	28	29	YES
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC) [3,5]	546.72	478.00	528.45	523.44	YES
Median Wait Time to Long-Term Care Home Placement – All Placements [3,4]	122.00	122.00	156.00	141.00	YES
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution [3,5]	21.20	21.00	27.80	26.35	NO
Rate of Emergency Department Visits that could be Managed Elsewhere [3,5]	70.03	62.40	76.83	69.91	NO
Re-admission Rates for Acute Myocardial Infraction (AMI) [3,5]	6.03	6.00	5.95	5.91	YES

Note:

* Performance indicators 1-7 = Fourth Quarter of 2008/09 and 8-12 = Third Quarter of 2008/09.

** Performance indicators 8-12 (in the Annual Results column) only includes the average of Quarters 1 to 3.

Report on MLAA Performance Indicators

At the end of 2008/09, the NE LHIN was unable to achieve five performance indicators identified in its MLAA.

The Cardiac By-Pass wait time was 38 days. The NE LHIN target for 2008/09 was 35. The NE LHIN has improved significantly from the initial starting point of 48 days and is still well below the provincial target of 182 days.

In the area of surgeries for hip and knee replacements, the NE LHIN was above the provincial target wait time of 182 days. The NE LHIN target for hips was 320 days and 290 days for knees. An improvement from the initial starting point of 405 days for hips and 380 days for knees was achieved.

Three of the most significant factors that had an impact on hip and knee surgeries were:

(1) Alternate Level of Care (ALC) patients. Our regional hospital had to cancel surgeries from October to December 2008 due to the high number of ALC patients in their acute care beds.

(2) Physician recruitment challenges.

(3) Lack of physiotherapists. Some of our communities are challenged with discharging patients due to the lack of physiotherapists in their small communities. This leads to patients staying longer in hospitals in order to receive physiotherapy services that are not readily available in their community.

During 2008/09, the percentage of ALC days* in NE LHIN hospitals was 26.35% as compared to the provincial target of 9.46%. The NE LHIN experienced an increase in ALC days; the starting point of 21% rose significantly to 27.8% in the third quarter of 2008/09. During this period, hospitals reached a crisis point where new transitional beds had to be opened to relieve pressures on the hospital system. The lack of long-term care beds and supportive housing units in our communities impedes a hospital's ability to discharge patients into a more appropriate setting. The wait lists for placements in some of our major communities exceeds 400 patients.

The rate of ER visits that could be managed elsewhere decreased from 70.03 to 69.61 in 2008/09. This is above our LHIN target of 62.40 and the provincial target of 11.79. Many of the communities in the NE LHIN do not have walk-in clinics or access to primary care, leaving the hospital as the only provider of health services in the community. The NE LHIN established a target for hospitals to reduce visits that could be managed elsewhere by 5% in 2008/09. The new Family Health Teams and Nurse Practitioner clinics will help the NE LHIN achieve further reductions.

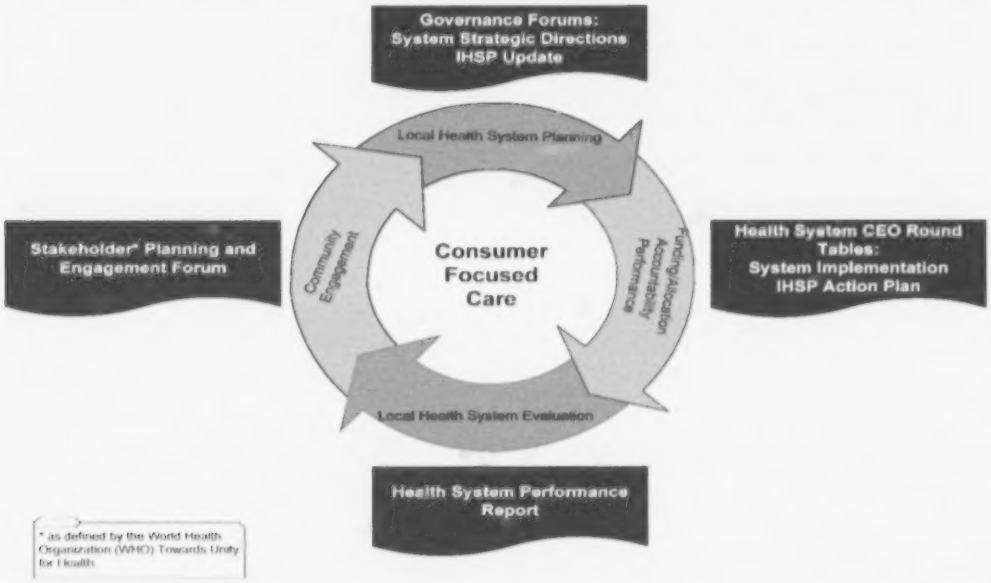
**Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment but remains in hospital due to a lack of supportive housing, long-term care home beds or home support services.*

IV. Community Engagement Activities

The purpose of community engagement is to hear from the users of the system. Through our various activities we are able to receive information on how community members perceive the system to be meeting their needs. Collectively, this information informs the NE LHIN on how to better achieve its vision of ***health and wellness for all***.

The NE LHIN's ***Community Engagement Strategy*** provides a framework to actively engage, empower and mobilize communities, stakeholders and the public in planning for an improved health care system. It also addresses and reflects the specific cultural needs and linguistic characteristics of the Francophone and Aboriginal/First Nation/Métis people within our region.

The NE LHIN ***System Planning and Implementation Cycle*** was established to ensure that all stakeholders were included in the process of identifying system level priorities and providing opportunities for implementation of strategic directions.



All aspects of this collaborative community engagement and planning approach have been integrated within the North East LHIN's planning and business cycle. This allows pertinent information and feedback to be captured in a timely manner. As identified in the diagram above, all stakeholders are included in one of the following settings:

I. Stakeholder/Community Groups: **Recommending system improvements**
   - Communities, health managers, policy makers, health professions, academic institutions

II. Governance Forums: **Setting System Directions**
   - Board members from LHIN-funded health service providers

III. Health System Round Tables: **Implementing Governance Directions**

- Senior leadership from health provider and partner organizations

IV. Health System Evaluations: **Evaluating System Performance**
- Consumer surveys, performance evaluations

This collaborative approach is carried out under the framework entitled ***Towards Unity for Health (TUFH)*** as developed by the World Health Organization. This framework "expresses the shared will of multiple partners to shape a sustainable health service based on people's needs." It is founded on the assumption that a coordinated or integrated approach is better than any other to improve quality, equity, relevance and cost-effectiveness in health. It speaks to the importance of engaging key partners/stakeholders in order to "establish a sustainable, people-based health service in line with values of quality, equity, relevance and cost-effectiveness."

In 2008/2009, the North East LHIN continued to seek out opportunities to engage with our health care community partners, boards, consumers and other allied professionals and representatives of our diverse cultural groups.

Stakeholder/Community Groups

An annual community engagement process contributes to recommendations for system improvements. Community engagement is held with the following identified NE LHIN stakeholders: communities, health managers, policy makers, health professionals, and academic institutions.

Governance Forums

Demonstrating innovation, the NE LHIN used technology to ensure its *2008 Governance/Stakeholder Forum* provided communication among individuals in urban and rural locations. The first-ever forum by videoconference gave 285 participants at 24 regional sites an opportunity for two-way communication across thousands of kilometres. Interested stakeholders joined the 3.5-hour evening meeting from Parry Sound to Moosonee, Hornepayne to Englehart, and Timmins to Mattawa, to discuss the economic downturn's impact on health care, how to stabilize ALC pressures, integration opportunities, and how the NE LHIN can collaboratively move from health service provider independence to interdependence.

Minister of Health and Long-Term Care, the Honourable David Caplan addresses the audience at the 2008 Governance Forum.

Health System Round Tables

Health System Round Tables continue to be an important community engagement vehicle for the NE LHIN. Our six round tables meet on a regular basis, primarily monthly, and contribute to planning in a number of important initiatives including; Aging at Home, ALC and the Integration Strategy, to name a few. Every investment made into the North East health care system is reviewed and endorsed by the round tables. Recommendations from round tables are brought forward to the NE LHIN Board of Directors for final approval.

Health System Evaluation

The actions of the NE LHIN are evaluated through the delivery of our Integrated Health Service Plan, an annual consumer survey and our MLAA performance indicators.

Community Engagement and the Aboriginal/First Nation/Métis People

During 2008 and continuing into 2009, the NE LHIN focused on:

- formalizing internal and external relationships, planning structures and processes for Aboriginal/First Nation/Métis engagement to ensure meaningful input into NE LHIN decision making; and
- correcting health information deficits for effective health planning.

In relation to these areas of focus, the NE LHIN developed Aboriginal specific integration strategy principles, a terms of reference for a NE Aboriginal Health Committee (legislated Aboriginal engagement committee and key advisory to the NE LHIN board and senior management) and established a number of regional subcommittees and quality representation into multiple regional working groups, task forces and committees.

The NE LHIN has also secured resources to undertake a comprehensive environmental scan and health service provider profiles.

Over the next year, the NE LHIN will develop the Local Aboriginal Health Committee structure, conduct an environmental scan and continue to align itself with provincial and federal health programs, services and initiatives to better meet the needs of our Aboriginal/First Nation/Métis people.

NE LHIN engagement activities with Aboriginal/First Nation/Métis people in 2008 and early 2009 included:

- Engaged with a four-member subcommittee to host a two-day Aboriginal Health Summit to: promote networking between Aboriginal, First Nation, Métis and mainstream health service providers and health sectors; discuss how to formalize an Aboriginal planning/advisory body within the NE (formerly the Local Aboriginal Health Planning Entity under LHSIA); and explore the use of technology in health planning and access to care. The Summit included three traditional teachers and Elders, 13 presenters, two expert panels and four small focus groups. A total of 120 Aboriginal/First Nation/Métis and mainstream health service providers participated.

- Developed a three member, Aboriginal Health Human Resource subcommittee of the NE Health Human Resource Planning Steering Committee.

- Named four First Nation and urban Aboriginal members to the Diabetes Strategy Management Steering Committee to oversee the development of the Diabetes Strategy and Diabetes Registry pilot projects.

- Hosted three face-to-face meetings and nine teleconferences with over 50 Aboriginal health and social service providers within the seven planning areas of the NE LHIN. These individuals assisted with the development and validation of the Local

Aboriginal Health Committee terms of reference and the selection of the first lead and alternate members.

- Developed seven Aboriginal specific principles for the NE LHIN Integration Strategy and supported an integration proposal to improve mental health services within the James and Hudson Bay Coasts.

- Named permanent lead and alternate Aboriginal members to the Health System Round Tables within each of the planning areas.

- Presented NE LHIN Aboriginal specific activities to the Ontario Hospital Association annual Aboriginal Health Conference and regular provincial Aboriginal LHIN Leads meetings.

- Hosted monthly meetings with two Interim Aboriginal Health Planning Committees to develop five new Aging at Home Strategy Proposals and two Year One project enhancements.

- Engaged and supported Aboriginal/First Nation/Métis health service providers in the development of year two, Aging at Home Strategy proposals. Approvals for new projects in 10 First Nation communities, and a number of rural and urban communities on Manitoulin Island and the Cochrane planning area are pending.

- Conducted a two day Mental Health and Addictions Strategic Planning Session with service providers within the James and Hudson Bay Coasts planning area.

- Submitted and received approval from the Aboriginal Health Transition Fund to support the following initiatives:

    - Traditional healing room at Timmins General Hospital;
    - Caregiver training by The Friends to community support service agencies in the Parry Sound planning area;
    - WAHA project management support;
    - Review of mental health and addictions services and development of a NE Aboriginal Mental Health Strategy;
    - Environmental scan

- Conducted a literature review and developed an action plan for Aboriginal/First Nation/Métis content within the Integrated Health Service Plan 2010-2013.

- Assisted the MOHLTC in the transition of Misiway Health Centre to the NE LHIN, long-term care home challenges and preliminary mental health and addictions programs and services review discussions.

- Participated in provincial, national and regional Aboriginal/First Nation health forums in e-health and health human resources.

Developed a Cree language medical translators list for community and health service providers during evacuations along the James and Hudson Bay Coasts.

NE LHIN Aboriginal/First Nation/Métis Interim Planning Group Members – *in operation until April 2009 and replaced by the North East Local Aboriginal Health Committee (NE LAHC):*

Regional Interim Aboriginal Health Planning Group Regular Member Participation

- Elder, North Bay and Temagami First Nation

- James Bay General Hospital, CEO & Manager of Patient Services
- Mamaweswin Tribal Council - North Shore, Health Director
- Nipissing First Nation Health Centre, Health Director
- Wikwemikong Health Centre, Health Director
- Wabun Tribal Council, Health Manager
- United Chiefs and Councils of Manitoulin - M'Chigeeng First Nation Health Centre, Health Director
- Noojmowin Teg Health Access Centre, Executive Director
- N'Mninoeyaa: Community Health Access Centre
- Shkagamik-Kwe Health Centre, Executive Director
- Métis Nation of Ontario, LTC Health Manager
- North Bay Indian Friendship Centre, Executive Director
- Timmins Friendship Centre, Executive Director
- Kapuskasing Friendship Centre, Executive Director
- Misiway Health Centre, Health Director

Intermittent Participation

- Union of Ontario Indians
- M'naamodzawin Health Services Inc.
- Weeneebayko General Hospital
- Wikwemikong Nursing Home, CEO
- Ontario Federation of Indian Friendship Centres, LTC Manager

James and Hudson's Bay Coastal Area Interim Aboriginal Health Planning Group Regular Member Participation

- James Bay General Hospital, Patient Care Manager & Assistant Executive Director, Patient Care
- James Bay Mental Health Program, Director
- Weeneebayko General Hospital, Director of Patient Care
- James Bay and Weeneebayko General Hospitals, Chief of Staff
- First Nations Inuit Health Branch, Community Care Services, Zone Officer
- Moose Cree First Nation, Long Term Care Manager, Health Director
- Mushkegowuk Tribal Council, Health Director
- Peetabeck Health Services Fort Albany First Nation, Health Director
- Peawanuck Health, Health and Wellness Coordinator
- Attawapiskat First Nation, Health Director
- Fort Albany, Health Director

Intermittent Participation

- Moosonee Indian Friendship Centre, Executive Director
- Sagashtawao Healing Lodge, Executive Director
- Public Health Unit, Nurse
- CCAC, Nurse and/or Personal Support Worker

Engaging with our Aboriginal, First Nation and Métis partners.

Community Engagement and the Francophone Population

The NE LHIN continues to move forward with French language service activities. The main focus of this past year was to proceed with the identification of all health service providers located in designated areas of the North East. Of a total of 83 mental health, addictions and community support services organizations, 25 organizations had already a partial or full designation and 58 were identified under the **French Languages Services Act.** As a designated or identified organization, the health service provider (HSP) must demonstrate how the francophone population is being served.

As a follow-up to the inclusion of a FLS equity index in the Hospital Service Accountability Agreement (H-SAA), a similar exercise was completed for all mental health, addictions and community support service sector organizations. This was done in collaboration with the Northern Office of French Language Health Services. The 83 identified or designated health service providers under the French Language Services Act now have, in their M-SAA, a FLS equity index. The response from the HSPs in completing the FLS Community Annual Planning Submission (CAPS) was exceptional. Only five organizations were unable to complete the required information. We are proud to report that 13 of our HSP's have attained the FLS equity index of "1" or more.

A FLS equity index of "1" suggests that access to and accessibility of services are fully equitable for the Francophone population. In this case, Francophone communities in the HSP's catchment area have equitable access to services in French. A FLS index greater than "1" suggests that access to and accessibility of services in French are more than equitable for the Francophone population.

For HSP's that have not attained the FLS equity index of "1", the goal is to improve their 2010/11 reported index by 10% by March 31, 2011. The FLS equity index is used to measure the equity of access to and accessibility of programs/services in French for the Francophone population.

This exercise is a first step in the NE LHIN's plan to move forward in evaluating how HSP's are providing accessible FLS services to the Francophone population in the North East.

The activities of the North East French Language Services Interim Planning Committee have been very minimal throughout the past year. The NE LHIN is still awaiting further direction from the Ministry regarding the mandate and direction for the provincially legislated planning entities. The NE FLS Interim Planning Committee agreed to suspend activities until Ministry direction is provided.

The NE LHIN continues to ensure that ongoing engagement activities are geared to the needs of Francophone stakeholders. Progress continues in this area with the development of a NE LHIN policy to address the specific needs of our Francophone population.

Integration Activities

In September 2008, our Board of Directors approved an **NE LHIN Integration Strategy.** The Strategy was developed to provide health service providers with information and a process to achieve success with health service integration and coordination efforts. The strategy supports integration activities that:

- enhance access to quality health care services for individuals;
- are patient-focused; and
- make the most effective and efficient use of available resources.

In 2008/09, the NE LHIN issued five voluntary integration orders supporting the following:

1. The integration of the Algoma Consumer Survivor Network and the Sault Area Hospital;
2. The integration of the North East Community Care Access Centre and the
3. The integration of the North Cochrane Addiction Services, the Moosonee Problem Gambling Program and the James Bay General Hospital – Community Mental Health Program.
4. The integration of Diagnostic Imaging Repository Services for North East, North West and Champlain LHIN hospitals;
5. The integration of the Rehabilitation Resources into the North Bay General Hospital.
6. West Parry Sound Health Centre Voluntary Service;

Integrated Health Service Plan (IHSP)

Progress continued to be made on the NE LHIN's IHSP which was published in December 2006 and covers the time period from April 2007 until March 2010. NE LHIN projects and activities continue to focus on the seven priorities contained within the NE LHIN's first IHSP which include:

- Aboriginal Health Services
- Chronic Disease Prevention and Management
- Coordinated Information and Communication Technology System and Information Management
- French Language Health Services
- Health Human Resource Needs
- Primary Care Reform
- Reduced Wait Times

Aboriginal Health Services

During 2008 and continuing into 2009, the NE LHIN focused on formalizing internal and external relationships, planning structures and processes for Aboriginal/First Nation/Métis engagement to ensure meaningful input into NE LHIN decision making, and correcting health information deficits for effective health planning. The NE LHIN was also a key partner in facilitating progress made with the Weeneebayko Area Health Authority (WAHA). The NE LHIN continues to ensure that ongoing engagement activities are focused on the needs of the Aboriginal/First Nation/Métis people.

Chronic Disease Prevention and Management

The NE LHIN will focus on the implementation of the provincial diabetes strategy. A diabetes management committee has been established with representation from across the region. The work of this committee will continue as preparations to implement a diabetes pilot project program continue.

Coordinated Information and Communication Technology System and Information Management

The NE LHIN has undertaken several large eHealth projects. Over the past year, the excellent eHealth leadership, champions and involvement has been cultivated among service providers. Engagement with providers has been a key success factor for any eHealth implementation and adoption and the NE LHIN will continue to build on these relationships. The NE LHIN was also identified as an early adopter of the rollout of the provincial eHealth Strategy and has been involved in the provincial eHealth priorities of diabetes management, medication management, e-physician and eHealth readiness.

French Language Health Services

The NE LHIN continued to move forward with French Language Service activities. The main focus of this past year was to proceed with the identification of all health service providers located in designated areas of the North East. As a designated or identified organization, the health service provider must demonstrate how its Francophone population is being served. The NE LHIN also continues to ensure that ongoing engagement activities are geared to the needs of Francophone stakeholders. A NE LHIN policy that will serve to address the specific needs of our Francophone population is currently under development.

Health Human Resource Needs

Work began in earnest with the establishment of the Health Human Resources Steering Committee. This committee, which has representation from across North East Ontario, is responsible for providing a system-wide leadership perspective on the development of North East Ontario Health Human Resources Plan. This plan will be aligned with local, cultural and language related health human resource issues.

Primary Care Reform

The priority of primary care will be addressed through the NE LHIN's work on chronic disease with an initial focus on diabetes management.

Reduced Wait Times

The NE LHIN's Wait Time Advisory Panel-Work Group meets quarterly to monitor the wait times and provide advice on a range of matters related to addressing challenges and opportunities in meeting our LHIN's wait time targets. In addition, the Surgical Optimization Study steering committee completed its draft report and prepared to conduct a focused consultation/engagement on the recommendations. The final report will be presented to the NE LHIN early in 2009 fiscal year.

A refresh of the NE LHIN's inaugural IHSP began in March 2009. During the first half of fiscal 2009, the NE LHIN will carry out an array of engagement activities to confirm and reaffirm NE LHIN priorities for 2010 to 2013.

V. NE LHIN Initiatives to Support Provincial Priorities and to Improve the Local Health Care System

Aging at Home

The Aging at Home Year 1 base funding increase helped address service and quality gaps in the health system for seniors. In moving forward with Year 2 funding, the focus was not only on further system enhancements, but on integration and innovation as key components to vitalize the service system for seniors.

Work continued with the ALC Task Forces and the Health System Round Tables in the NE LHIN's seven planning areas to develop Year 2 Aging at Home proposals (Year 2 funding covers fiscal years 2009/10; however the planning work was completed in 2008/09).

A total of $6.2 million was allocated to the NE LHIN in Year 2 to support seniors to live healthy, active and independent lives in their own homes longer. A total of 42 Aging at Home projects were submitted from the various planning areas across the North East. The NE LHIN is now moving forward with the approval process for Year 2 projects and implementation of Year 1 projects.

Alternate Level of Care (ALC)

Many of the NE LHIN's 25 hospitals continue to face significant ALC challenges. The NE LHIN has concentrated much of its efforts on the large four urban centres/hospitals which account for 60% of ALC pressures in the North East.

In November 2008, the NE LHIN approved a five-point action plan to continue to help resolve ALC pressures across the North East. The priorities (beds and housing options, wrap around services, integrated care, nurse-outreach teams, and aging at home) are in keeping with the NE LHIN's ALC Action Plan (December, 2007) which focuses on relieving ALC pressures through two main strategies: (1) building resource and system capacity and (2) making improvements in care delivery processes.

In Sudbury, the North East's regional referral centre, a joint physician – NE LHIN ALC Steering Group was established in late 2008. The Group identified ten priorities for action to both alleviate immediate pressures and reduce future ALC challenges in Sudbury. The progress of this group is being closely monitored to ensure its successes can be implemented in other NE LHIN communities who are also experiencing ALC pressures.

Amongst the North East four urban centres (Sudbury, North Bay, Sault Ste. Marie and Timmins), a number of other initiatives showed great progress with helping to stabilize ALC pressures, including: ALC Wrap Around Services, Identification of Seniors-at-Risk Screening Tool (ISAR); a Geriatric Emergency Management Program, and the Flo Collaborative, to name a few.

ALC will continue to be a priority in 2009/10. Knowing that ALC is a long-standing health system issue, the NE LHIN will continue to bring all community partners around the table to work on short, medium and long-term solutions.

eHealth Diabetes Strategy and Registry

The NE LHIN received one-time funding of $175,000 to implement a Diabetes Registry. Over the next fiscal year, we will be conducting regional ehealth diabetes care "current state assessments" as well as identifying leaders who will assist with the launching of the initiatives.

The NE LHIN was one out of five LHINs identified to support the roll-out of the Ontario Diabetes Strategy and received $51,000 in one-time funding to establish a Diabetes Management Committee and to identify a pilot project in an Aboriginal community.

Physician eHealth Strategy

Timmins District Hospital and the Timmins Family Health Team (FHT) partnered to implement an electronic medical record for the Timmins FHT. $280,000 in one-time funding will be used to also develop the interface between the hospital and the health team.

Aboriginal Transitional Fund

The NE LHIN submitted proposals to the Ministry of Health and Long-term Care for funding to support Aboriginal projects within the North East. One-time funding of $45,374 was received to begin work on an environmental scan, support a mental health conference and to cover project management costs associated with the development of the Weeneebayko Area Health Authority (WAHA). The projects will continue into 2009/10 and the NE LHIN will receive an additional $193,500 in one-time funding for these purposes.

Urgent Priority Funding

During the 2008/09 year, the NE LHIN allocated its $2.9 million in Urgent Priority funding in support of our growing senior population and ALC pressures. Transitional beds in both Sudbury and Sault Ste Marie were funded on a one-time basis and ALC Wrap Around Programs were implemented in Sudbury, Sault Ste Marie, North Bay and Timmins.

In addition, the NE LHIN provided funding to two supportive housings projects in North Bay and Elliot Lake and provided $400,000 for start-up of the Regional Geriatric Program. A key component of the geriatric program is the linkages with other service providers throughout the North East who work together to ensure that seniors effectively access the programs and services they need to remain in their own homes.

Supportive Housing

The NE LHIN is the first LHIN in Ontario to commission a housing report to look at the current and future needs of seniors in terms of long-term care, retirement or assisted living, and supportive housing. The ***Seniors' Residential Housing Options Report*** indicates that additional supplies of supportive housing options are required in the coming 25 years, both for a growing number of seniors, and suited to the needs of those in the more elderly age groups.

Further to this study, the NE LHIN has confirmed the need for a strategy to address ALC that goes beyond existing health care programs and focuses specifically on supportive housing. The plan must include the commitment to work on building capacity within the community through the right mix of long term care beds, supportive housing and community support services.

Emergency Room Wait Times

The Wait Time Advisory Panel-Work Group meets quarterly to monitor the wait times and provide advice on a range of matters related to addressing challenges and opportunities in meeting our LHIN's wait time targets. The two objectives of the committee are to: ensure that wait time procedures needed by people living in North East Ontario are received as close to home as possible; and ensure that wait time targets are met through re-allocation of funds to hospitals within the NE LHIN region that have capacity and can deliver services in a timely manner.

Analysis of LHIN Operational Performance

Our People

During the course of the year, the NE LHIN added a new position to support our responsibilities related to our Aboriginal/First Nations/Métis communities. This brings the NE LHIN staffing complement to 23 full time positions.

Our staff are carefully recruited for a skill base that allows the organization to effectively deliver on its mission of ***Health and Wellness for All***. The combined skills of our staff reflect expertise in Aboriginal/First Nation/Métis health planning, Francophone health planning, health planning and integration within the remote and rural geography of North East Ontario, data collection and analysis, community engagement, financial processes and negotiations, and communications.

Throughout the year, the NE LHIN held retreats to review the workload and priorities of our staff. These staff consultations led to the implementation of a project management approach to assist in the effective management of NE LHIN priorities and associated projects

Our Fiscal Responsibility

The NE LHIN managed its responsibilities with a balanced budget in 2008/09.

A large portion of the NE LHIN budget is allocated to travel costs. With a region that spans 400,000 square kilometres and is home to more than 550,000 people in rural, remote and urban communities, travel is a mainstay for NE LHIN staff and Board members.

Board of Director's meetings are held on a monthly basis and rotate among each of the seven planning areas, allowing Board Directors to meet with stakeholders in their own communities and personally hear issues and concerns regarding the local delivery of health care services. In turn, the people of our region have the opportunity to engage with the NE LHIN and to offer input into the best approach to providing health care across a geographically dispersed and culturally diverse region.

NE LHIN staff travel extensively to meet with health service providers and consumers. This past year, the NE LHIN staff negotiated 25 hospital service accountability agreements (H-SAA), and 135 Multi Sectoral Accountability Agreements (M-SAA) which required additional travel and training sessions.

VI. Financial Statements

Financial statements of

North East Local Health Integration Network

March 31, 2009

North East Local Health Integration Network

March 31, 2009

Table of contents

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Auditors' Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the statement of financial position of the North East Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the North East Local Health Integration Network as at March 31, 2009 and the results of its operations, changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 7, 2009

North East Local Health Integration Network

Statement of financial position
as at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**968,385**	1,167,075
Due from MOHLTC	**3,701,600**	1,686,710
	4,669,985	2,853,785
Liabilities		
Accounts payable and accrued liabilities	**817,949**	1,092,476
Due to MOHLTC (10b)	**128,332**	66,646
Due to the LHIN Shared Services Office (Note 3)	**22,104**	7,953
Due to Health Service Provides ("HSP")	**3,701,600**	1,686,710
Deferred capital contributions (Note 4)	**213,966**	388,750
	4,883,951	3,242,535
Net debt	**213,966**	388,750
Non-financial assets		
Capital assets (Note 5)	**213,966**	388,750
Accumulated surplus	-	-

Approved by the Board

M L Bazinet

Director

Peter Nardy

Director

North East Local Health Integration Network

Statement of financial activities

year ended March 31, 2009

	Budget (unaudited) (Note 6)	2009 Actual	2008 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,154,299,500**	**1,169,655,493**	1,115,633,592
Operations of LHIN	**4,832,335**	**4,796,665**	3,802,494
E-Health (Note 9a)	**-**	**600,000**	275,000
Emergency Department Lead (Note 9b)	**37,500**	**75,000**	37,500
Aboriginal Engagement (Note 9c)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund (Note 9d)	**-**	**45,374**	-
Emergency Room/Alternate Level of Care (Note 9e)	**-**	**33,300**	-
Diabetes Strategy (Note 9f)	**-**	**51,000**	-
Aging at Home	**-**	**-**	202,000
Wait Time Strategy	**-**	**-**	70,000
Amortization of deferred capital contributions (Note 4)	**-**	**210,454**	195,823
	1,159,269,335	**1,175,567,286**	1,120,316,409
Expenses			
Transfer payments to HSPs (Note 7)	**1,154,299,500**	**1,169,655,493**	1,115,633,592
General and administrative (Note 8)	**4,832,335**	**4,796,665**	3,801,412
E-Health (Note 9a)	**-**	**534,131**	274,739
Emergency Department Lead (Note 9d)	**37,500**	**60,000**	30,000
Aboriginal Engagement (Note 9c)	**100,000**	**99,035**	100,000
Emergency Room/Alternate Level of Care (Note 9e)	**-**	**32,728**	-
Diabetes Strategy (Note 9f)	**-**	**50,448**	-
Aging at Home	**-**	**-**	202,000
Wait Time Strategy	**-**	**-**	70,000
Amortization of capital assets	**-**	**210,454**	195,823
	1,159,269,335	**1,175,438,954**	1,120,307,566
Annual surplus before repayable to MOHLTC	**-**	**128,332**	8,843
Funding repayable to MOHLTC (Note 10a)	**-**	**(128,332)**	(8,843)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**	**-**	-
Closing accumulated surplus	**-**	**-**	-

North East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2009

	2009	2008
	$	$
Annual surplus		
Acquisition of tangible capital assets	**(35,670)**	(160,961)
Amortization of tangible capital assets	**210,454**	195,823
Decrease in net debt	**174,784**	34,862
Opening net debt	**(388,750)**	(423,612)
Closing net debt	**(213,966)**	(388,750)

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2009

	2009	2008
	$	$
Operating		
Annual surplus	-	-
Items not affecting cash		
Amortization of capital assets	**210,454**	195,823
Amortization of deferred capital contributions (Note 4)	**(210,454)**	(195,823)
Changes in non-cash working capital		
Decrease in accounts receivable	-	2,231
Increase in due from MOHLTC	**(2,014,890)**	(1,686,710)
(Decrease) increase in accounts payable and accrued liabilities	**(274,527)**	919,939
Increase in due to MOHLTC	**61,686**	8,843
Increase (decrease) in due to the LHIN Shared Services Office	**14,151**	(76,798)
Increase in due to Health Service Providers ("HSP")	**2,014,890**	1,686,710
	(198,690)	854,215
Investing		
Acquisition of capital assets	**(35,670)**	(160,961)
Financing		
Increase in deferred capital contributions (Note 4)	**35,670**	160,961
Net (decrease) increase change in cash	**(198,690)**	854,215
Cash, beginning of year	**1,167,075**	312,860
Cash, end of year	**968,385**	1,167,075

North East Local Health Integration Network

Notes to the financial statements
March 31, 2009

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets and losses in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

4. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**388,750**	423,612
Capital contributions received	**35,670**	160,961
Amortization	**(210,454)**	(195,823)
Balance, end of year	**213,966**	388,750

5. Capital assets

			2009	2008
	Cost	**Accumulated amortization**	**Net book value**	Net book value
Furniture and fixtures	**70,404**	**50,925**	**19,479**	33,560
Computer equipment	**92,788**	**63,664**	**29,124**	40,421
Leasehold improvements	**725,033**	**559,670**	**165,363**	314,769
	888,225	**674,259**	**213,966**	388,750

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,169,655,493 is made up of the following:

	$
Initial budget	**1,154,299,500**
Adjustment due to announcements made during the year	**15,355,993**
Total budget	**1,169,655,493**

The total operating funding budget of $5,737,009 is made up of the following:

	$
Initial budget	**4,969,835**
Additional funding received during the year	**767,174**
Total budget	**5,737,009**

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,169,655,493 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2009	2008
	$	$
Operation of Hospitals	**735,395,697**	701,409,702
Grants to compensate for Municipal Taxation - Public Hospitals	**249,825**	244,950
Long Term Care Homes	**168,778,614**	156,362,614
Community Care Access Centres	**93,802,009**	88,054,570
Community Support Services	**21,398,759**	20,531,038
Acquired Brain Injury	**1,263,094**	-
Assisted Living Services in Supportive Housing	**8,069,412**	7,241,600
Community Health Centres	**8,569,291**	6,530,373
Community Mental Health	**47,495,109**	47,223,620
Substance Abuse & Problem Gambing	**19,424,774**	18,355,753
Specialty Psychiatric Hospitals	**65,193,759**	69,659,347
Grants to compensate for Municipal Taxation - Psychiatric Hospitals	**15,150**	20,025
	1,169,655,493	1,115,633,592

8. General and administrative expenses

The Statement of Financial Activities presents the expenses by function; the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and wages	**2,404,290**	1,795,529
HOOPP	**254,296**	180,254
Other benefits	**251,173**	178,330
Staff travel	**245,695**	204,862
Governance travel	**68,463**	69,131
Communications	**91,240**	138,332
Accommodation	**160,409**	156,509
Advertising	**54,668**	40,234
Banking	**25**	554
Consulting fees	**539,596**	287,336
Equipment rentals	**20,044**	18,818
Governance per diems	**129,575**	118,258
Insurance	**15,930**	15,930
LHIN Shared Services Office	**300,000**	300,000
Other meeting expenses	**32,031**	95,405
Other governance expenses	**29,441**	2,132
Printing and translation	**73,748**	24,533
Staff development	**36,446**	46,863
IT equipment	**37,117**	25,451
Office supplies and equipment	**45,119**	44,904
Other	**7,359**	58,047
	4,796,665	3,801,412

9. a) E-Health expense

The E-Health office of the Ministry of Health and Long-Term Care provided $600,000 to the LHIN. The LHIN had a contract and retained the services of the Group Health Centre (the "GHC") during 2009. The GHC provided services and deliverables as described in the contract. In return, the LHIN agreed to reimburse the GHC for expenses incurred during the performance of this work. The total amount of expenses reimbursed during the duration of this contract was $534,131.

b) Emergency Department Lead (ED Lead)

The Ministry of Health and Long Term Care announced they would be providing the LHIN an additional $75,000 in one-time funding to (a) pay the LHIN ED Lead $5,000 per month as well as (b) money to reimburse the LHIN ED Lead for any expenses. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2008 are $60,000.

9. c) Aboriginal Engagement

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations with the North East LHIN. The total amount of expenses paid using this funding was $99,035.

d) Aboriginal Health Transfer Funding (AHTF)

The Ministry of Health and Long Term Care provided an additional $45,375 in one-time funding for AHTF Adaption projects that were submitted for funding by the LHIN. A formal request has been made by the LHIN to carry this money forward into 2010.

e) Emergency Room/Alternate Level of Care

The Ministry of Health and Long Term Care provided $33,300 in one-time funding to help the LHIN in supporting the North East ER/ALC Performance Lead. The total amount of expenses paid using this funding was $32,728.

f) Diabetes Strategy

The Ministry of Health and Long Term Care provided $51,000 in one-time funding to help the LHIN in supporting the Ontario Diabetes Strategy. The total amount of expenses paid using this funding was $50,448.

10. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC is made up of the following components:

	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	**1,169,655,493**	**1,169,655,493**	-
LHIN operations	**4,796,665**	**4,796,665**	-
Amortization of capital assets	**210,454**	**210,454**	-
E-Health	**600,000**	**534,131**	**65,869**
Emergency Department Lead	**75,000**	**60,000**	**15,000**
Aboriginal Engagement	**100,000**	**99,035**	**965**
Aboriginal Health Transfer Fund	**45,374**	-	**45,374**
Emergency Room/Alternate Level of Care	**33,300**	**32,728**	**572**
Diabetes Strategy	**51,000**	**50,448**	**552**
	1,175,567,286	**1,175,438,954**	**128,332**

b. The amount due to the MOHLTC is made up of the following components:

	2009	2008
	$	$
Opening balance	**66,646**	57,803
Funding recovered by the MOHLTC	**(66,646)**	-
Funding repayable to the MOHLTC (Note 10A)	**128,332**	8,843
Closing balance	**128,332**	66,646

11. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 24 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $254,296 (2008 - $180,254) for current service costs and is included as an expense in the Statement of Financial Activities.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2010	172,247
2011	50,938
2012	7,286
2013	6,563
2014	2,703

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2009 the LHIN had signed Accountability Agreements with all Hospitals and Community Agencies for the next two years. The actual amounts that will ultimately be paid to HSPs are contingent on receipt of anticipated levels of funding from MOHLTC.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.